

IPDR6702		NORTH CAROLINA		PAGE: 1			
RUN DATE: 03/19/2006		IPRS CHECKWRITE SUMMARY REPORT					
		CHECKWRITE DATE: 03/21/2006					
		FINANCIAL PAYER: NCMMH					
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL
NUMBER	PROVIDER NAME	ROBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	CLAIMS PAID
3404901	SMOKY MOUNTAIN H/CD/SAS	8505	3	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET			
		0	0		0	3	3 0
3404904	WESTERN HIGHLAN DS LME	11	127	CLIENT NOT ELIGIBLE ON SERVICE DATE			
		191	31	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0	207	5821 5614
		9000	22	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL			
3404910	FATHWAYS	8505	775	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET			
		21	193	DUPLICATE OF CLAIM-SYSTEM	1	1584	4451 2867
		11	152	CLIENT NOT ELIGIBLE ON SERVICE DATE			
3404912	CATAMBA COUNTYM ENTAL HEALT	8505	1799	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET			
		9800	84	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	16	1919	2388 469
		11	10	CLIENT NOT ELIGIBLE ON SERVICE DATE			
3404913	MECKLENBURG COM ENTAL HEALT	8599	39	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			
		8952	13	CLAIM DENIED DUE TO AGE RESTRI CTIONS FOR TARGET POPULATION	0	55	127 72
		11	2	CLIENT NOT ELIGIBLE ON SERVICE DATE			
3404916	CROSSROADS BEHA VIGORAL HEAL	24	14	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TTYPE OF SERVICE COMBINATI			
		0	0		0	14	14 0
3404917	CENTERPOINT SUM AN SERVICES	8505	763	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET			
		8518	43	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	24	867	897 30
		8622	27	60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.			
3404918	ROCKINGHAM CO M ENTAL HEALT	0	0	*** NO DATA TO REPORT ***			
		0	0		0	0	0 0

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL REAS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404919	GUILFORD CO MEN TAL HEALTHC	8505	2172	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8599	94	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	39	2439	7320	3392
		11	49	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404920	ALAMANCE CASWEL L AREA MH D	8518	538	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
		8599	97	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	32	923	5074	4151
		79	86	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
3404921	ORANGE PERSON C HATHAM AREA	8505	429	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8599	83	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	8	674	3706	3032
		8000	55	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				
3404922	THE DURHAM CENT ER	8599	251	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8518	179	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	31	575	774	199
		8505	34	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
3404923	FIVE COUNTY MH	11	145	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		8599	57	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	307	5412	5105
		8518	35	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
3404925	SANDHILLS CENTE R FOR MH/DD	8505	2885	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8599	236	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	8	3808	8478	4670
		8800	157	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE PAY'S.				
3404926	SOUTHEASTERN RE G MENTAL HL	11	251	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		8599	94	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	397	2619	2222
		8533	39	SERVICE FACILITY LOCATION CANN OT BE AN ATTENDING PROVIDER IDENTIFIED AS AN INDIVIDUAL.				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL ROBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404927	CUMBERLAND CO M HC	8505	149	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8622	83	60 RESIDENTIAL LEVEL III TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.	21	445	1158	713
		8000	79	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				
3404929	LEE HARNETT MH/ DD/SAS	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404930	JOHNSTON COUNTY MNTL HLTHC	8599	155	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8621	25	60 RESIDENTIAL LEVEL III TREAT MENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.	1	182	1220	1038
		8935	1	ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
3404931	WAKE CO HUM SVC BILLING OF	27	24	DIAGNOSIS CODE MISSING OR INVA LID. VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUB				
		9308	23	PRIOR AUTHORIZED UNITS EXCEEDS D	3	111	1097	984
		8599	12	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404933	SOUTHEASTERN CT R FOR MH/DD	8599	115	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		79	77	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN	37	293	1243	950
		8000	30	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				
3404934	ONSLow CARTERET BEHAV HEAL	8000	182	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				
		10	161	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CTD. DIAGNOSIS, PROCEDURE CODE FOR	42	941	2421	1480
		8599	140	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404935	WAYNE CO MENTAL HEALTH CTR	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404936	WILSON-GREENE M ENTAL HEALT	8505	168	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8599	140	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	3	317	1358	1041
		8931	3	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
3404937	EDGEcombe NASH MNTL HLTH C	21	12	DUPLICATE OF CLAIM-SYSTEM				
		191	4	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0	20	1399	1379
		11	3	CLIENT NOT ELIGIBLE ON SERVICE DATE				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL REBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404938	VOFW DBA RIVERS TONE COUNSE	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404939	NEUSE MENTAL HE ALTH CENTER	8599	72	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8505	47	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET	0	126	545	419
		10	6	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR				
3404941	FITT CO MH/DD/S AS CENTER	8535	1206	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR EST. PLEASE RESUBMIT YOUR CLAIM WIT				
		8599	1007	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	14	3670	8109	4439
		4102	620	YOU ARE ATTEMPTING TO ADJUST A CLAIM THAT IS EITHER NOT FOUND ON OUR FILE OR IS NOT FO				
3404942	ROANOKE CHOMANN UMAN SERVIC	21	37	DUPLICATE OF CLAIM-SYSTEM				
		11	32	CLIENT NOT ELIGIBLE ON SERVICE DATE	9	121	572	451
		8599	27	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404943	ALDENABLE MENTA L HEALTH CE	79	59	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
		8931	31	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	47	209	1493	1284
		9404	29	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MCD				
3404944	EASTPOINTE HUMA N SERVICES	21	71	DUPLICATE OF CLAIM-SYSTEM				
		8621	27	60 RESIDENTIAL LEVEL III TREAT MENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.	9	188	1542	1354
		8599	26	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404946	FOOTHILLS AREAM ENTAL HEALT	11	407	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		9000	236	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL	35	1141	3587	2446
		8599	145	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				

PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404957	TIDELAND MENTAL HEALTH CTR	8599	160	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8000	43	NO RATE AVAILABLE ON FILE TO F RICE THIS CLAIM DETAIL	11	247	4590	4343
		79	14	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
3404979	NEW RIVER AREAM H/CD/SA PRO	8505	199	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8000	160	NO RATE AVAILABLE ON FILE TO F RICE THIS CLAIM DETAIL	77	663	4858	4195
		8599	82	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				